South Dakota Application for Medicare Savings Program

NOTE: This is **NOT** an application for full Medicaid, cash assistance, or food stamps. If you want to apply for these programs, contact your local Social Services office. This application **CAN** be used for a single person or a couple (self and spouse).

1. INSTRUCTIONS:

Read the application carefully and follow all instructions given throughout the form. 1. Answer each question completely and accurately. Attach additional pages if needed. 2. If you need help completing or understanding this form, contact the Department of Social Services in the county where you live. 3. Include copies of all documents that are available to you. **Do not send original documents.** 4. Sign and date the application. 5. Mail the application to your local Social Services Office**.** 6. An interview is not required for these programs**.**	AGENCY USE ONLY Case No. _____ Date Received _____

2. PERSONAL INFORMATION: Completion of Race, Social Security Number (SSN), and citizenship is optional for persons NOT requesting assistance.

Name (Last, First, Middle Initial)	Race(can check more than one) ( ) White ( ) American Indian ( ) Black ( ) Hawaiian ( ) Asian	Ethnicity Also check here if Hispanic ( )
Birthdate Sex Marital Status	**If someone else is completing this form, provide the following information for the individual completing the form.**	
Social Security Number U.S. Citizen ❑Yes ❑No	Name (Last, First, Middle Initial)	
Street Address	Street Address	
City State Zip	City State Zip	
Phone County	Phone	
Nursing Facility (if applicable)	Relationship to Individual	

3. INFORMATION ON SPOUSE: Complete this information even if not applying for spouse.

Spouse's Name	Birthdate	Sex	Race	U.S. Citizen	Social Security Number (Optional, if spouse is not applying.)
				❑Yes ❑No	
Address of Spouse if Different from Applicant:					
Are you applying for Medicare savings for your spouse, too? ❑Yes ❑No					

4. INFORMATION ON DEPENDENTS:

Dependents name	Birthdate

5. LIVING ARRANGEMENT: Check the one box (❑) that describes current living situation.

	In Own Home	Renting	In Other's Home	Other (example: shelter)
Self	❑	❑	❑	❑Describe:
Spouse	❑	❑	❑	❑Describe:

6. INFORMATION ON MEDICARE:

Attach **copies** (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? ❑Yes ❑No	Type of Coverage **(Check Each Box that Applies)** ❑Part A ❑ Part B	Effective Date	Medicare ID Number
Does your spouse have Medicare? ❑Yes ❑No	Type of Coverage **(Check Each Box that Applies)** ❑ Part A ❑ Part B	Effective Date	Medicare ID Number

7. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? **❑Yes** **❑No**

Does your spouse have other health insurance? **❑Yes** **❑No**

If you, or your spouse, have other insurance, please complete the following information.

	Health Insurance Company Name **and** Company Address	Annual Premium	Type of Coverage (Hospital, Medigap, RX)	Effective Date	Policy Number
Self		$			
Spouse		$			

8. INCOME AND EARNINGS:

List all types of earnings and income that you, your spouse, or dependent receives. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stub, benefit letter, etc.), **do not send original documents**. Examples of income include:

* Social Security
* SSI
* Wages/ Self-Employment
* Railroad Retirement Benefits
* Veterans' Benefits
* Trust or Annuity Payments
* Pensions/ Retirement Benefits
* Rental Income
* Oil Royalties/ Mineral Rights

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	ID Number (if applicable)

9. PROPERTY:

Do you or your spouse own all or part of any real estate? ❑**Yes** ❑**No**

If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you, or your spouse, own a car, truck, motorcycle, boat, trailer, or other vehicle? ❑**Yes** ❑**No**
If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

10. RESOURCES:

List all types of resources (assets) owned by you or your spouse. Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as copies, not originals, of your most recent bank statement, trust funds, etc) of all resources. Examples of resources:

*Checking account
*Savings account
*Government bonds
*Trust Funds
*Funeral plans/ burial arrangements
*Burial plots
*Stocks and Bonds
*Certificate of Deposit
*Cash on Hand
*Safety Deposit Box
*Retirement Funds
*Other

Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

11. LIFE INSURANCE:

Do you, or your spouse, have a life insurance policy? ❑Yes ❑No
If yes, please complete the following information.

Policy Owner	Insurance Company Name and Address	Policy Number	Face Value	Cash Value

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party that may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS:

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased QMB recipients. QMB co-payments and deductibles will be subject to estate recovery only if the recipient received any of the following services: Nursing facility, Home-Community Based Services (if over age 55), Intermediate Care Facility for the Mentally retarded (ICF/MR) and Hospital (in-patient and out-patient) This recovery is only on the amount of Medicaid expended for the above services on behalf of the QMB recipient. There is no recovery for physician or clinic services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be a liable recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended for the above services on behalf of the applicant. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by the recipient who has received a benefit from the Department of Social Services of a nursing facility, and intermediate care facility for the mentally retarded, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the Department at the time of death.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose. Any person who feels that his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing BOP/DSS, PMB 0141-2, Bureau of Personnel, 500 East Capitol, Pierre, SD 57501-5070 or calling (605) 773-6941.

I certify that I (or if filing for my spouse, my spouse and I) am an U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**